FROM THE GOP HEALTH CARE TASK FORCE . . .

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Summary of the "Patients' Bill of Rights Plus Act" as Passed by the U.S. Senate July 15, 1999

This summer, the Senate passed landmark legislation that dramatically reshapes health insurance in America. The "Patients' Bill of Rights Plus Act" (S. 1344), which passed 53-47 without a single Democrat vote, provides patients' rights unparalleled by any federal legislation in more than a generation. The "Patients' Bill of Rights Plus Act":

- Represents the most significant congressional effort to establish consumer protection standards for health plans since 1974.
- Improves the health coverage options of more Americans than the Health Maintenance Organization (HMO) Act of 1973, the Employee Retirement Income Security Act (ERISA) of 1974, or the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
- Imposes new minimum standards on health plans beyond the reach of state regulation, while allowing states to regulate other health plans and insurance products according to their own needs.
- Makes health insurance more affordable, empowers individuals to take control of their health care, and corrects inequalities present in the tax code since World War II by making health insurance fully deductible for the self-employed and by allowing all Americans to purchase medical savings accounts (MSAs).

In short, this landmark legislation gives families the protections they want and need, ensures that medical decisions are made by physicians in consultation with their patients, and makes health insurance more affordable for those who are struggling to afford it or who have none at all.

Since its passage, much misinformation has been spread about the "Patients' Bill of Rights Plus Act" — largely by a Democrat minority that supported a bill (S. 6) that would have canceled the health coverage of 1.8 million Americans. The following summary details how this legislation provides strong patient protections, enhances health care quality, and increases access to health coverage. The bill contains seven major components:

1) **Establishes patient protections for the 48 million Americans not covered by State protections.**

2) **Provides consumers with information to compare health insurance options.** This information will be available to the 124 million Americans covered by both self-insured and fully insured group health plans.

3) **Sets up procedures for appealing coverage denials** (internally and externally) for the 124 million Americans covered by both self-insured and fully insured group health plans.

4) **Requires health plans to cover a hospital stay for the treatment of breast cancer** for the 140 million Americans covered by self-insured, fully insured group, and individual health insurance plans.

5) **Bans insurers and plans from using predictive genetic information** for underwriting purposes, protecting the 140 million Americans covered by self-insured, fully insured group, and individual health insurance plans.

6) **Establishes the Agency for Health Care Research and Quality** to conduct research on health care quality improvement.

7) **Gives all Americans access to medical savings accounts (MSAs); allows the self-employed to fully deduct their health insurance costs; and allows employees to fully deduct long-term care insurance** that is not employer-subsidized — all provisions assuring more Americans will be able to afford health insurance.

These new protections are established without a significant increase in the cost of health coverage — because what good are patient protections if you cannot afford health insurance?

1. Patient protection standards for self-funded plans:

Since States already regulate fully insured health plans, the bill provides the following standards for health plans not regulated by the States — that is, it covers the 48 million Americans in employer-sponsored, self-funded group health plans that are governed exclusively by the Employee Retirement and Income Security Act (ERISA):

Emergency Care: Requires plans to use the "prudent layperson" standard for providing in-network or out-of-network emergency services at the same cost to the patient. The required services include emergency ambulance services, emergency screening exams, stabilization, and care required to maintain medical stability until follow-up care is arranged.

Choice of Plans: Requires plans that offer network-only plans to offer enrollees the option to purchase point-of-service coverage. Employers with 50 or fewer workers are exempt. Also exempt are employers in areas where a point-of-service option is not readily available.

OB-GYN/Pediatricians: Requires health plans to allow patients direct access to gynecologists and pediatricians for routine care within their fields without referral and direct access to obstetricians for maternity services without referral.

Continuity of Care: Plans that terminate or do not renew providers in their networks must notify enrollees and allow continued use of the provider (at the same payment and cost-sharing rates) for up to 90 days if the patient is receiving institutional care; until the end of life if the patient is terminally ill; and, in the case of a pregnancy, through post-partum care. This provision also applies when a patient's provider is terminated because an employer changes its health plan network.

Access to Medication: Health plans that provide prescription drugs through a formulary must ensure the participation of physicians and pharmacists in developing and reviewing that formulary. Plans must also provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate for the patient.

Access to Specialists: Health plans must ensure that patients have timely access to specialists appropriate to the patient's condition and age. The plan must provide for an appropriate number of referrals for specialty care.

Gag Rules: Prohibits plans from in any way restricting providers from communicating with patients about their medical condition and treatment options.

Self-pay for Behavioral Health: Prohibits plans that offer behavioral health services from barring a participant from himself paying for behavioral health care services.

Access to Approved Cancer Clinical Trials: Plans must provide coverage of routine patient costs for cancer clinical trials sponsored by the National Institutes of Health, the Department of Veterans Affairs, or the Department of Defense.

Provider Nondiscrimination: To the extent necessary to meet the needs of a

plan's enrollees, plans are prohibited from discriminating, based solely on licensure, against any provider's participation in the plan's network.

2. Comparative Information:

All group health plans must provide a wide range of comparative information about health insurance coverage, such as descriptions of the networks, cost-sharing information, and medical necessity definitions to the 124 million Americans covered by both self-insured and fully insured group health plans.

3. Grievance and Appeals:

All group health plans must have written grievance procedures and have both an internal and independent external appeals procedure for the 124 million Americans covered by both self-insured and fully insured group health plans.

Time frames for internal and external review: Routine requests must generally be completed within 30 days, and expedited requests for care that could jeopardize enrollees' health must be handled within 72 hours.

Qualifications of external reviewer: The reviewer(s) must be an independent medical expert in the same specialty as the treating provider and must have age-appropriate expertise in the diagnosis and treatment involved. The reviewer cannot have any conflict of interest with the case or parties involved.

Standard of review: The external reviewer(s) must make an independent medical determination based on the relevant clinical and scientific evidence and must consider a wide range of information, including evidence offered by the patient and the patient's physician, generally accepted medical practice and expert opinion, peer-reviewed literature, and the plan's evidence-based criteria and clinical practice guidelines.

External appeals process: Enrollees and their authorized providers may appeal to independent external medical reviewers for coverage denials that are based on a determination of medical necessity or whether a treatment is experimental. To appeal a medical necessity determination, the denial of treatment would have to involve an amount above a significant financial threshold or place the enrollee's health in jeopardy.

Plans may select an external review entity, which must be certified as meeting specific criteria established by the State or Federal Government for this purpose. The review entity would then designate an independent medical expert as the reviewer(s).

Enforcement: The external review determination is binding on plans. The reviewer will recommend a time-table for the commencement of the treatment. If a plan refuses to comply with the reviewer's recommendation, the patient may seek the treatment from any provider and the plan, not the patient, will be liable to reimburse the provider. If a plan does not comply on a timely basis, there is a mandatory $10,000 penalty assessed on the plan, payable to the patient. Also, the plan is subject to a penalty of up to $10,000 for failing to meet the time frames established for the external review process.

4. Mastectomy Length of Stay and Second Opinion:

All group health plans and health insurance issuers must cover a hospital stay for the treatment of breast cancer.

5. Genetic Information

All group health plans and health insurance issuers are prohibited from denying coverage, or adjusting premiums or rates based on "predictive genetic information" for the 140 million Americans covered by both self-insured and fully insured group health plans and individual health insurance plans. The term "predictive genetic information" includes an individual's genetic tests, genetic tests of family members, or information about family medical history.

6. Federal Investment in Health Care Research and Quality Improvement

The bill refocuses the Agency for Health Care Policy and Research (and renames it the Agency for Healthcare Research and Quality) to encourage overall improvement of quality in the nation's health care systems. The new agency will facilitate state-of-the-art information systems, support primary care research, conduct technology assessments, and coordinate the Federal Government's own quality improvement efforts.

7. Making Health Insurance More Affordable

The bill expands coverage by allowing the self-employed to fully deduct their health insurance costs, making medical savings accounts available to all Americans, and allowing full deductibility of long-term care insurance that is not employer subsidized.

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